State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Enclosed is the Medi-Cal provider enrollment application package you requested. Requests for additional application packages should be directed to EDS, the Medi-Cal fiscal intermediary, at 1-800-541-5555.

PLEASE NOTE: New regulations (effective February 2003) governing the enrollment of providers in the Medi-Cal program now require additional information to be submitted with the application package. Applications will be reviewed to ensure that applicants and providers meet the new criteria, including the verification of insurance.

Instructions for completion of these documents are included on the forms. Please read the instructions carefully. If after reading the instructions you have questions regarding the completion of the application, disclosure statement and/or provider agreement, you may call the Provider Enrollment Branch at (916) 323-1945 between the hours of 8 a.m. and 5 p.m. to leave a message. Each applicant is sent written notice when the application package is received. Due to the volume of applications received, program staff is unable to reply to a request for the status of applications in process. Therefore, please allow for the 120 days stipulated in regulations for processing your application prior to contacting the Department regarding the status of your application. Application packages that are incomplete or are submitted on a form other than the current Department of Health Services (DHS)-issued forms will be returned to you.

It is your responsibility to report to DHS any changes to information previously reported on the enrollment documents within 35 days of the change. Most changes may be reported on a *Medi-Cal Supplemental Application*. You may request a *Medi-Cal Supplemental Application* by contacting EDS.

For more information on the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our Web site at **www.medi-cal.ca.gov** and click on "Publications," then "Provider Enrollment."

If you have any questions, please the call Provider Enrollment Branch at (916) 323-1945.

Provider Enrollment Branch
Payment Systems Division

Enclosures

(Revised 2/03)

MEDI-CAL TRANSPORTATION PROVIDER APPLICATION

FOR STATE USE ONLY

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: Department of Health Services
  Provider Master File Unit
  P.O. Box 942732
  Sacramento, CA 94234-7320
  (916) 323-1945

Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check one) | Date

❒ New provider

❒ Change of ownership—Current Medi-Cal provider number: _____

❒ Additional business address—Current Medi-Cal provider number: _____

❒ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, California Code of Regulations, Section 51000.55.) Current Medi-Cal provider number: _____

Type of entity

❒ Sole proprietor ❒ Partnership ❒ Government

❒ Corporation: ❒ Limited liability corporation: ❒ Other: _____

Corporate number: _____ Corporate number: _____

State incorporated: _____ State incorporated: _____

Type of transportation

❒ Emergency ❒ Both

❒ Nonemergency

Specific mode of transportation (check all that apply)

❒ Wheelchair van ❒ Helicopter ❒ Litter van

❒ Fixed-wing ❒ Both wheelchair and litter van ❒ Ambulance

1. Legal name of applicant or provider (as listed with the IRS) (last) (first) (middle)

2. Business name, if different

3. Business telephone number ( )

Is this a fictitious business name? ❒ Yes ❒ No

If yes, list the Fictitious Business Name Statement number

Effective date

(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement.)

4. Business address (number, street)	City	County	State	Nine-digit ZIP code

5. "Pay to" address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

6. Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

7. Federal Employer Identification Number (FEIN) (Attach a legible copy of the IRS form.)

___ ___ – ___ ___ ___ ___ ___ ___ ___

8. Social security number or Individual Taxpayer Identification Number (ITIN) (If Sole Proprietor not using a FEIN, you must disclose this number and attach a legible copy of the ITIN verification, if applicable.) (See Privacy Statement on page 3.)

___ ___ ___ – ___ ___ – ___ ___ ___ ___

9. Medicare billing number

10. Business days and hours of operation:

Days: _____ Hours: _____

11. Geographic area(s) served (list city/county—attach copy of permit/license)

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12. Ambulance and Driver Information—*see instructions* (attach separate sheet, if necessary)

Ambulance

CHP Certificate Number	Issue Date	Vehicle Identification Number(s)	Make and Model of Vehicle	Year	License Number

Ensure legible copies of the following documents are attached to the application:

❒ CHP certificate(s)

❒ DMV vehicle registration

Driver Information

Name	California Driver's License Number	Ambulance Driver Certificate Number

Ensure legible copies of the following documents are attached to the application:

❒ California Driver's License for each driver

❒ California Ambulance Driver Certificate

13. Aircraft and pilot information—*see instructions* (attach a separate sheet, if necessary)

Aircraft Information

FAA Certificate Number	Name and Address Where Aircraft is Hangared

Ensure a legible copy of the following document is attached to the application:

❒ FAA Certificate

Pilot Information

Name	Pilot's License Number

Ensure a legible copy of the following document is attached to the application:

❒ FAA Pilot's License for each pilot

14. Litter and/or Wheelchair Van/Driver Information—*see instructions* (attach a separate sheet, if necessary)

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Litter and/or Wheelchair Van Information

Vehicle Identification Number(s)	Make and Model of Vehicle	Year	License Number

Ensure legible copies of the following documents are attached to the application:

❒ DMV vehicle registration ❒ Brake and Lamp Certificate

❒ Proof of insurance

Driver Information

Name	California Driver's License Number

Ensure legible copies of the following documents for each driver are attached to the application:

❒ DMV driving record printout ❒ California Driver's License

❒ Certificates for first aid and CPR ❒ DMV DL-51 form signed by a physician

❒ Standard pre-employment drug and alcohol tests lab results

Information About Individual Signing This Application

15. Printed name of individual signing this application (last) (first) (middle)

16. Gender ❒ Male ❒ Female

17. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

18. Date of birth

19. Social security number (***Optional***—see Privacy Statement below.)

____ ____ ____ – ____ ____ – ____ ____ ____ ____

20. **I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider.**

Signature of the person authorized to bind the applicant or provider

Title

Executed at: _____, _____ on _____
(City) (State) (Date)

21. Notary Public

Privacy Statement
(Civil Code, Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code, Section 14043.2(a) and Title 22, California Code of Regulations, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Health Care Financing Administration, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, Sacramento, CA, (916) 323-1945.

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL TRANSPORTATION PROVIDER APPLICATION

DO NOT USE correction tape, white out, etc.; highlighter pen or ink of a similar type on this form.

This form is an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers may also need to provide additional information and documentation. Applicants may be subject to an on-site inspection prior to enrollment. In addition to the application, the attached disclosure statement and a provider agreement must also be completed for enrollment.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations, Section 51000.50.

Enrollment Action Requested (check one); enter the date you are completing the application.

"New provider" means the applicant is not currently enrolled in the Medi-Cal program and would like a Medi-Cal provider number issued.

"Change of ownership" means the ownership of the applicant or provider has changed by 50 percent or more.

"Additional business address" means the applicant is currently enrolled in the Medi-Cal program and is requesting a Medi-Cal provider number for an additional business location.

"Continued Enrollment" means the provider is currently enrolled in the Medi-Cal program and would like to continue participation. Enter the provider number that you would like to continue to use. (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Regulations Section 51000.55.)

"Type of entity": Check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, please attach a legible copy of the partnership agreement.

"Type of transportation": Check all that apply.

"Specific mode of transportation": Check all that apply.

1. "Legal name" means the name listed with the Internal Revenue Service (IRS).
2. "Business name" means the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement to the application.
3. "Business telephone number" means primary business telephone number used at the business address. A beeper number, answering service, pager, facsimile machine, biller or billing service, or answering machine may not be used as the primary business telephone.
4. "Business address" means the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.
5. "Pay to address" means the address to which payment will be mailed and should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
6. "Mailing address" means where the applicant or provider wishes to receive general Medi-Cal correspondence, if different from the business address. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
7. Enter the Federal Employer Identification Number (FEIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of IRS Form 941, Form 8109-C, Form 147-C, Form SS-4 (Confirmation Notification), or Form 2363.
8. If the business is a sole proprietorship not using a FEIN, provide the social security number or Individual Taxpayer Identification Number (ITIN) of the Sole Proprietor. Attach a legible copy of the ITIN verification, if applicable.
9. Enter the applicant's or provider's Medicare Billing number.
10. "Hours of operation" are business days and hours that the applicant or provider is available for service to Medi-Cal beneficiaries.
11. "Geographic area(s) served" means those areas in which you will be transporting Medi-Cal beneficiaries. Attach a copy of the city/county business license/permit to the application. If the city/county does not require a license/permit, you must attach a letter from that city/county confirming licensing/permit requirement with the application. It is the applicant's or provider's responsibility to verify with the city/county in which transportation services will be provided for vehicle and driver's permits. If you intend to conduct business in either the City of Los Angeles or the City of San Diego, you must apply for their vehicle and driver's permits. For more information, contact either the City of Los Angeles Department of Transportation or the San Diego Metropolitan Transit Development Board.
12. Provide the following information:

    Ambulance:

    ❒ Certificate number issued by the California Highway Patrol (CHP). Attach a legible copy of the certificate to the application.
    ❒ Issue date.
    ❒ Vehicle Identification Number (VIN) of each vehicle that will be used to transport beneficiaries.
    ❒ Make and model of vehicle.
    ❒ Year of vehicle.
    ❒ License plate number of vehicle.

Driver information:
❒ Full legal name of driver.
❒ Driver's license number
❒ Ambulance Driver Certificate number.

13. Provide the following information:
❒ Certificate number issued by the Federal Aviation Administration (FAA). Attach a legible copy of the certificate to the application.
❒ Name and address where the aircraft is hangared. This statement must also be on your company letterhead and be attached to the application.

Pilot information:
❒ Full legal name of pilot.
❒ Pilot's license number—the number issued by the FAA on the pilot's license of the individual listed.

14. Provide the following information:

Litter and/or wheelchair van:
❒ VIN of each vehicle that will be used to transport beneficiaries.
❒ Make and model of vehicle.
❒ Year of vehicle.
❒ License plate number of vehicle.

Driver:
❒ Full legal name of driver
❒ Driver's license number

15. "Printed name of individual signing the application" means first, middle, and last name of any individual acting on behalf of and with the authority to legally bind the applicant or provider as the sole proprietor, partner, corporate officer, or government official when applying to the Department for enrollment or continued enrollment as a provider in the Medi-Cal program.

16. Check (✓) the gender of the individual named in number 15.

17. Enter the driver's license or state-issued identification number and state of issuance of the individual listed in number 15. Attach a legible copy.

18. Enter the date of birth of the individual named in number 15.

19. Provide the social security number of individual listed in number 15 (***optional***, see Privacy Statement on page 3).

20. An original signature is required of the individual named in number 15. Enter the title of the person signing the application; include city, state, and date where and when the application was signed.

21. The application must be notarized by a Notary Public. The Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

✓ Remember to attach a legible copy of the following, if applicable:

❒ Fictitious Business Name Statement
❒ FEIN or ITIN verification
❒ CHP certificates
❒ DMV commercial vehicle registration
❒ Proof of insurance
❒ Brake and Lamp Certificate
❒ FAA certificate
❒ FAA Pilot's License for each pilot
❒ Driver's license for each driver
❒ Certificates for first aid and CPR for each driver
❒ DMV DL-51 form signed by a physician for each driver
❒ Standard pre-employment drug and alcohol tests lab results for each driver
❒ DMV driving history printout for each driver
❒ City/county business license/certificate
❒ Driver's license or state-issued identification card of person signing the application